DRAFT

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM ADOPT

PROVIDER SELF-CERTIFICATION OF COMPLETION OF TRAINING IN THE PROVISION OF PARAMEDICAL SERVICES

IHSS Recipient Name: _____

IHSS Recipient Case Number: _____

IHSS Provider Name: _____

IHSS Provider Number: _____

The IHSS program recipient named above is authorized to receive Paramedical Services. Paramedical Services are services that require judgment based on training provided by a Licensed Health Care Professional (LHCP), that are necessary to maintain a recipient's health and that he/she would normally perform for himself/herself if not for his/her functional limitation(s). Some examples of Paramedical Services include, but are not limited to, oral administration of medicine, giving injections, catheter care, blood or urine testing and tube feeding. The specific Paramedical Service(s) the recipient needs has/have been ordered by his/her LHCP.

Before you can receive payment from the IHSS program for providing Paramedical Services for this recipient, you must receive training directed by a LHCP to administer the specific Paramedical Service(s) ordered by the recipient's LHCP. Only the following LHCPs can direct your training: Physician/Surgeon/Doctor of Osteopathic Medicine (D.O.), Podiatrist, Physician Assistant (PA), Nurse Practitioner (NP) Dentist. If you have not yet been trained on how to provide the Paramedical Service(s) ordered you will not receive payment for providing the recipient's authorized Paramedical Service(s).

You must complete, sign and date this form and return it to the county at the address listed below in order to provide the Paramedical Service(s) ordered for the IHSS recipient named above as a part of the IHSS program. If you receive training on a new Paramedical Service, you will be required to complete a new SOC 321A, indicating the Paramedical Service(s) and the date you were trained; or, the LHCP must submit a new SOC 321 with the appropriate sections completed.

Please check the box of the LHCP who directed your training (check all that apply):

☐ Physician/Surgeon/D.O. ☐ Podiatrist ☐ Physician Assistant (PA) ☐ Nurse Practitioner (NP)

☐ Dentist

NAME OF LHCP AND PHONE NUMBER	TYPE OF PARAMEDICAL SERVICE TRAINED ON	DATE TRAINED

IHSS PROVIDER DECLARATION

BE SURE YOU HAVE READ EVERY ITEM AND ANSWERED ALL THE QUESTIONS THAT APPLY TO YOU. READ THE FOLLOWING CAREFULLY BEFORE SIGNING:

I certify that I have received training directed by a LHCP on the Paramedical Service(s) listed on this form.

I accept the responsibility of performing the Paramedical Service(s) to the IHSS recipient named above and I understand that the County and State of California are immune from any related liability.

I declare that I have read and understand the requirements as stated in this document.

I agree to comply with these requirements.

I understand that a copy of this declaration will be provided to this IHSS recipient for his/her records.

I THE UNDERSIGNED DECLARE UNDER PENALTY OF PERJURY THAT THE FORGOING STATEMENTS ARE TRUE AND CORRECT.

IHSS PROVIDER'S SIGNATURE ▶	DATE

Return to: (County Social Services/IHSS Department)

THE FOLLOWING TO BE COMPLETED BY THE COUNTY:

Copy of SOC 321A provided to IHSS recipient on _____ (DATE)	SOCIAL WORKER'S or Public Health Nurse's NAME	
Copy of SOC 321A filed in IHSS provider's file on _____ (DATE)	SOCIAL WORKER'S or Public Health Nurse's SIGNATURE ▶	DATE